Rev. 3/19

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON

Ms. Naomi Sue White Eagle
Plaintiff's full name and prisoner number

Plaintiff,

v.

J. Michaelis, Holdway

Dr. Clay,

B. Duncan et. al
Defendant's/defendants' full name(s)

Defendant(s).

(If you cannot fit all of the defendants' names in the space provided, please write "see attached" in the space above and attach additional sheets of paper, as necessary, with the full list of names. The names listed here must be identical to those in Section II. Do not include addresses here. **Individuals whose names are not included in this section will not be considered defendants in this action.**)

Case No. 3:22-cv-05410-BHS-TLF
(leave blank – for court staff only)

AMENDED
PRISONER CIVIL RIGHTS COMPLAINT

Jury Demand?
☒ Yes
☐ No

WARNINGS

1. Do not use this form if you are challenging the validity of your criminal conviction or your criminal sentence. If you are challenging your conviction or sentence, or if you are seeking restoration of good-time credits that would shorten your sentence, you must file a Petition for Writ of Habeas Corpus. If you use this form to challenge your conviction or sentence, you risk having your claim dismissed. Separate forms are available for filing a habeas petition.

2. Under the Prison Litigation Reform Act ("PLRA"), you are required to exhaust all remedies in your institution's grievance system that are available to you before filing suit. This generally means that you must file a grievance and, if it is denied, appeal it through all available levels of review. Your case may be dismissed if you fail to exhaust administrative remedies, unless the administrative grievance process was not "available" to you within the meaning of the PLRA. You are not required to plead or show that you have exhausted your claim in this complaint.

3. Please review your complaint carefully before filing. If your case is dismissed, it may affect your ability to file future civil actions while incarcerated without prepaying the full filing fee. Under the PLRA, a prisoner who has had three or more civil actions or appeals dismissed as frivolous, malicious, or for failure to state a claim cannot file a new action without first paying the full filing fee, unless the prisoner is in imminent danger of serious bodily injury.

4. Under Federal Rule of Civil Procedure 5.2, papers filed with the court, including exhibits or attachments to a complaint, may not contain certain information, which must be modified as follows:

Do not include:	Instead, use:
• a full social security number	→ the last four digits
• a full birth date	→ the birth year
• the full name of a minor	→ the minor's initials
• a complete financial account number	→ the last four digits

5. You may, but do not need to, send exhibits, affidavits, grievances, witness statements, or any other materials to the Clerk's Office with this complaint. Any documents you submit *must relate directly to the claims you raise in this lawsuit.* They will become part of the court record and *will not be returned to you.*

I. PLAINTIFF INFORMATION

White Eagle Naomi Sue , Lowe Lowell Gene
Name (Last, First, MI) Aliases/Former Names

855988
Prisoner ID #

Airway Heights correction center
Place of Detention

~~[illegible]~~ po Box 2049
Institutional Address

Spokan Airway Heights WA 99001
County, City State Zip Code

Indicate your status:

- ☐ Pretrial detainee
- ☐ Civilly committed detainee
- ☐ Immigration detainee
- ☒ Convicted and sentenced state prisoner
- ☐ Convicted and sentenced federal prisoner

II. DEFENDANT INFORMATION

Please list the following information for each defendant. If the correct information is not provided, it could delay or prevent service of the complaint. Make sure that the defendant(s) listed below are identical to those contained in the caption on the first page of the complaint. Attach additional sheets of paper as necessary.

Defendant 1: michaelis J
Name (Last, First)

RN, CS2
Current Job Title

NU
PO Box 2049
Current Work Address

Spokane Airway Heights WA 99001
County, City State Zip Code

Defendant 2: Holdway melisa LMHC, psycahology Associate
Name (Last, First)

LMHC psycahology Associate
Current Job Title

Po Box 2049
Current Work Address

Spokane Airway Heights WA 99001
County, City State Zip Code

Defendant 3: clay D. edva, L
Name (Last, First)

Psychologist (In D,I,D ect) - AN
Current Job Title

2800 E. madison st. Suite 302
Current Work Address

King Seattle WA 98112
County, City State Zip Code

III. STATEMENT OF CLAIM(S)

In this section, you must explain what you believe each defendant did to violate your civil rights, and if you know, identify the federal statutory or constitutional right you believe was violated.

If you believe the defendant(s) violated your civil rights in more than one way, explain each violation under a different count. For example, if you believe you received constitutionally inadequate medical care and your religious rights were substantially burdened, include one claim under "Count I" (i.e., medical) and the other claim under "Count II" (i.e., religion).

Number your paragraphs. For example, in Count I, paragraphs should be numbered 1.1, 1.2, 1.3, etc., and in Count II, paragraphs should be numbered 2.1, 2.2, 2.3, etc. The first two paragraphs of each Count have been numbered for you.

If you have more than three counts, attach additional pages and follow the same format for each count.

If you attach documents to support the facts of your claim(s), you must specify which portion of the document(s) (i.e., page and paragraph) you are relying on to support the specific fact(s) of your claim(s). If you do not specify the portion of the supporting document(s), the Court may disregard your document(s).

COUNT I

Identify the first right you believe was violated and by whom:

1.1 8th Amendment Insufficient medical care, showing a deliberate Indifference by Defendant[S] Haldway, michaelis

State the facts of your first claim below. Include all the facts you consider important. Be specific about dates, times, locations, and the names of the people involved. Describe exactly what each specific defendant did or failed to do that caused you injury or violated your rights, and include any other facts that show why you believe what happened was wrong. If you need additional space, you may attach extra sheets.

1.2 "Plaintiff brings facts & statements of show cause & statements stating that on 12-27-2021 Plaintiff followed up & filed a medical kite responded back by Defendant Haldway stating Plaintiff's medical concerns / issues of Plaintiff's stomach

& bowel problems were of no concern by Defendant[s] being told would be scheduled appointment / follow up in the coming weeks (Jan 1, 2022) having no results refusing to hear Plaintiff's concerns, Plaintiff further more moved within the weeks of filing medical complaint concerns. causing more of a Intentional Interference & Indifference. As Defendant[s] did fall short in & to Plaintiff's medical need & concern. Saying & stating concern of Plaintiff is of No concern to Defendants.

• Plaintiff have, having been documented with stomach & bowel issues/ problems being neglected & have put in medical kites said only of no concern & Defendant[s] would / will follow up being untreated knowing of Plaintiff's pain & requests only to be said further by Defendant Holdway to try & draw, play games or do crosswords [Pl Doc #12 pg 4] Holdway completely ignoring medical issues & concerns as if all is in Plaintiff's head. Plaintiff having requested of medical need / concern & such stomach / bowel problems documented see, [Pl Doc #2] only upon requests Defendants continued to state [See Pg 5A & 5B & 5C

State with specificity the injury, harm, or damages you believe you suffered as a result of the events you described above in Count I. Continue to number your paragraphs.

Plaintiff states injury & harm is lack of care & concern of & by Defendants letting Plaintiff continue in & with Pain + suffering due to their unconcern & lack of medical care violative of Plaintiff's rights Pain + suffering. Punitive, injunctive, compensatory damages. Seeking proper care - surgery within 4-5 months. $ 885.000.000

will follow up sessions, having made known issues & document since noted herein see [PL DOC #2] as of 3-20-2020 / 2021 which can be further verified by & through medical documents, & providers. medical providers have continually & constantly said - told Plaintiff, medical issues are of No concern & to do word puzzles which is Not a proper medical treatment, Nor is it a sufficient medical treatment, As Defendants have put Plaintiff's concerns on the way side As to NO concern. which does then become medical Neglect & does further show deliberate Indifference & Intentional Interference, leaving Plaintiff in pain & suffering knowing of Plaintiff's requests & concerns of pain & suffering, having had documented H. pylori & prior medical issues & concerns. see [PL DOC #2] having medical records of such & such made issues / concerns made known, prior & documented prior by medical providers. Plaintiff further more states as to Defendants acts / actions Holdway does show unconcern & clear disregards to Plaintiff's requests & concerns; stating as to Plaintiff's medical concern & issues to try & do word cross word puzzles & games. PL DOC #2 pg 4) And clear & plain negligence / neglect of medical procedures & practices, violative of the 8th Amendment as to Plaintiff's medical need & response.

See pg 5B

Pg 5B

being improper medical treatment. Further negligence & unconcern, neglect creates & does cause future risk / risks of further harm, damage leaving Plaintiff in pain & suffering longer than need be treating Plaintiff as to a bandaid on a wound which is unsufficient care & treatment & not the answer to Plaintiff's medical need & concern; " creating future risks of harm leaving in pain and prolonged pain & suffering. being of unconcern. Also see that as to " Jett v. Penner 439 f.3d 1091 (9th cir 2006) " McGuckin v. Smith 974 f.2d 1050, 1059, (9th cir 1992) & " Helling v. McKinney 509 u.s. 25, 32-35 (1993) Such stomach & bowel pain & on going issues does significantly affect Plaintiff's daily activities. • Defendant[s] knew & know of Plaintiff's concern failing & falling short to properly treat & or to sufficient treat Plaintiff. Defendant[s] DO show neglect & unconcern towards Plaintiff, telling Plaintiff providers will schedule & see Plaintiff unto follow ups, Not following through as to Plaintiff's continued requests to medical / Defendant[s] unconcern & care, which in turn is violative of proper & adequate medical care, showing Indifference by Not treating Plaintiff & showing unconcern. Giving rise to future risks & Infliction pain & suffering. more over further violative of same similar situated persons & treatment. As to offender Health care, WAC: 137-91-01 & health care Act

see 5C

5C

Health care, medical Necessity. Per WAC: 137-91-010 Defendant[s] failing & did fail to show unconcern of criteria acting within Indifference to WAC: 137-91-010 by not following standards, protocols, procedures & criteria. And such is violative of & by Defendant[s] By & of one or more of the follow criteria is not followed, and/or neglected. Further making mention that Plaintiff does have & suffers further from Gender Dysphoria.
1.) Is essential to preserve life or limb OR 2.) Reduce Intractable pain, OR 3.) Delay of care would make future care or intervention significantly less likely to succeed. OR
4.) Reduces severe psychiatric, symptoms to a degree that permits the palpably, medically Necessary care for Plaintiff is to reduce the severity with which Plaintiff suffers daily (due to constant & continued stomach & bowel pains which is clearly & plainly documented by Plaintiff.) further suffering from her Gender dysphoria, As future surgery could have considerable detrimental effects upon Plaintiff's advanced age, As risks progress with geriatric patients surgeries. Surgery will reduce the severe psychiatric symptoms Plaintiff experiences due to her female presentation & her natural male genitalia. the severe mental anguish Plaintiff experiences would be abated by surgery & lesser treatments. which serve penological interests, & remove the ability for recidivism, or self harm, Due to nonfeasance to treat Plaintiff's serious medical needs.

COUNT II

Identify the second right you believe was violated and by whom:

2.1 8th Amendment, Improper & Negligence of proper medical/ health care by Defendant[s] Dr clay, Holdway, michaelis.

State the facts of your second claim below. Include all the facts you consider important. Be specific about dates, times, locations, and the names of the people involved. Describe exactly what each specific defendant did or failed to do that caused you injury or violated your rights, and include any other facts that show why you believe what happened was wrong. If you need additional space, you may attach extra sheets.

2.2 Plaintiff states Defendant(s) clay, Holdway, michaelis Airway Heights correctional medical staff/ providers did fall short in regards to Plaintiff's medical requests & concerns making known & have/ has been made known as is documented unto Plaintiff's illnesses & wellness of stomach & bowel issues/problems. Defendant(s) stating is of No concern, yet is document & Plaintiff was further scheduled for H. pylori testing & colonoscopies only to be rescheduled & further continuances of rescheduling having delays & hinderances unto concerns & requests, Plaintiff only being told medical will follow up & reschedule/ schedule testings & colonoscopies. Defendant(s) further more issued a limited supply of anti-biotics to try & limit / put off Plaintiff's treatment, only to be followed up as to repeated statements of & by Defendants stating will follow up & reschedule, Plaintiff requesting & questioning unto said follow ups & rescheduling; further requesting said antibiotic refills being given a limited & small quantity.

which as to & per such said request & concern, Defendant[s] responded saying is No record of antibiotics & medications of & for said Plaintiff, Plaintiff having been issued & prescribed medications & antibiotics, having (Kup medical cards) & Rx prescribed medical sheets info. from medications. See [Pl. Doc #12 pgs] Attach. Defendants improper & misrepresention, misstated statements [See pg 7A & 7B]

State with specificity the injury, harm, or damages you believe you suffered as a result of the events you described above in Count II. Continue to number your paragraphs.

Plaintiff suffered severe emotional & mental Anguish, insufficient care, further being in continued distress & discomfort from stomach & pains & bowel pains which Defendants left Plaintiff in a cruel & infliction state of pain. Violative of 8th Amendment & RCW 51.24.020

COUNT III

Identify the third right you believe was violated and by whom:

3.1 insufficient & Non sufficient medical / Providers showing indescrepancies & difficientcies, as to sufficient care / Needs

State the facts of your third claim below. Include all the facts you consider important. Be specific about dates, times, locations, and the names of the people involved. Describe exactly what each specific defendant did or failed to do that caused you injury or violated your rights, and include any other facts that show why you believe what happened was wrong. If you need additional space, you may attach extra sheets.

3.2 Plaintiff states allegations & cause of Defendant(s) by stating negligence of Defendant(s) actions / acts & response to Plaintiff's medical issues - concerns. As Defendant(s) did show & state lack of concern & improper handling of medical Rites & concerns of Plaintiff as is unprofessional conduct & Remedies

is contridiction & invalidation to medical file, official documents, medical records. Defendant[s] act within & show deliberate indifference & own interests; Having flawed & mis stated documents & records which is clear Negligence & improperness of & unto medical matters & proper procedures/ guidelines & such is more over misleading & misinterpretation of facts & statements. which is violative & clearly & plainly & knowingly by Defendant[s] that Defendant[s] did violate & did not follow properness, violating that of Rcw: 42.20.040, 42.20.050, 9.24.050. And wDOC policies 600.000 - 650.100, 700.000, 100.500 As to medical Applications & procedures, treating fairly & within reason as to offenders. As to Rcw's & policies; states "one can not alter, conceal, with hold, and or make a false or misleading state." which in turn Defendant[s] did and is violative further unto (18 U.S.C § 1505,) (15 U.S.C § 1311 et seq.) As one/Any who so does such shALL be guilty of a class b felony & is punishable up to 5yrs. Such by Defendant[s] Is & does show misappropriation of & to record further as to Rcw: 40.16.020 [see Also PL DOC H2] stating Plaintiff has had antibiotics & medication refills yet Not on Plaintiff's file or medical records as Need be & required, As Defendants try to Legitimize & Regulate, Alter & conceal - make misleading statements as to Plaintiff's records & file & such is

improper, as one should act/operate in a efficient & in a effective manner. Violative of also false statute 35.01 As Defendant(s) did fail & did fall short by their actions to safeguard Plaintiff from dubious & unjustness, hinderances & forfeitures of life, liberty, property. Brinegar v. U.S. 69 S. Ct. 1302 (1949)

Defendant(s) only gave Plaintiff a limited & insufficient supply amount of antibiotics putting a band aid as to Plaintiff's concern & medical Needs/problems. Plaintiff's concern having been documented and improperly treated & responded too. Causing Plaintiff further anguish & pain which does give rise to cruel infliction of pain by letting Plaintiff suffer, And is improper acts/actions by Defendants saying Plaintiff's issues & concerns are of No Concern to Plaintiff & will follow up & talk to Plaintiff only to reschedule upon reschedule. And putting Plaintiff in further pain, distress, discomfort. Giving rise as to Defendant(s) being violative of causing Intentional & Emotional distress. Also see, Kumar v. Gate Gourmet INC. 180 Wn 2d 481) Allahu Al-Hafeez 226 F.3d 247 (3rd Cir 2000) Also As to RCW 51.24.020 Carnell v. Grimm 872 F. Supp. 746 755 (9th Cir)

as Defendant(s) did fail to proper respond to medical kites & Grievances unto Plaintiff's medical concerns & follow up statements. Defendant(s) in doing so did fail Plaintiff in right to be heard. As Defendant(s) ignored complaints & concerns of Plaintiff by saying/stating will follow up & or stating continued rescheduling's. And Grievances being stated providers/medical is aware of Plaintiff's concern, issues, pain. Defendant(s) showed failure to exhaust/properly respond. Foulk v. Charrier 262 f.3d 687, 698) Jett v Penner 439 f.3d 1091, 1096 (9th cir) Defendants acts/actions do hinder & show unsatisfactory conditions by failing to properly provide reasonable treatment & access. Allard v. Gomez 9 fed. App. 793 (9th cir) Starr v. Baca 652 f.3d 1202) ortiz v. city of Imperial 884 f.2d 1312) Hallett v. morgan 296 f.3d 732, 744) As by further hindering & Delaying matters defendants do & did violate RCWs 9A.76.020, 72.70.010, 9A.80.010 As is considered neglect. Defendant(s) Did fail to properly respond & treat Plaintiff, telling Plaintiff to do & try crossword puzzles/games, only furthering Plaintiff's pain & discomfort. Powe v. Ennis 177 (see pg 8A)

State with specificity the injury, harm, or damages you believe you suffered as a result of the events you described above in Count III. Continue to number your paragraphs.

Plaintiff suffers ongoing pain & suffering due to insufficient use of antibiotics & future risks of health problems & further anguish, distress & discomfort violative of RCWs 51.24.020, 9A.80.010 9.94A.030, 13.04.030, continued pain, discomfort & distress.

IV. RELIEF

State exactly what you want the Court to do for you. For example, you may be seeking money damages from an individual defendant, you may want the Court to order a defendant to do something or to stop doing something, or you may want both kinds of relief. Make no legal arguments. Cite no cases or statutes.

Plaintiff seeks Relief as to correct medical care/treatment, (medications) Declaratory Judgment "Rights effected by statute 85,000, Intentional violations as to treble damages 70,000, Collateral Relief, for error, mistakes, neglect - to correct (give proper medical treatment/medications,) compensation 140,000,000 for continued pain, discomfort suffering, All costs, fees, 15,000 Injunctive 30,000 Punitive 80,000

V. SIGNATURE

By signing this complaint, you represent to the Court that you believe the facts alleged to be true to the best of your knowledge, that you believe those facts show a violation of law, and that you are not filing this complaint to harass another person or for any other improper purpose.

8/22/2022
Dated

Ms. Naomi See White Crow
Plaintiff's Signature

f.3d 395, 394 (5th cir 1999) causing further Infliction of unnecessary & need pain & suffering. Keeton Et AL § 32 at 175) ● Defendants Did write a prospectus report, exhibit, or statement saying no medications on or of record requesting refills or a sufficient supply stated by out side health care provider as documented. Such statements by Defendants is exaggerated and clearly shown in [PL DOC H2] As to providers (Defendants) responses. [PL DOC H2 pg's, H3, H5, H12, & H15] H15 stating no record of such files / medications. Such statements & misleading contridictions are violative of RCW. 9.24.05 (medical records being certified documents)) ● Such medical necessary If further defined as to stated which Defendants did act within a unreasonable manner & fell short of services. "As health care services that are determined by physician to be reasonable & necessary to protect life, prevent significant illness or disability or alleviate severe pain; "severe pain" Is defined as a degree of discomfort that significantly disables the patient from reasonable independent function. & significant illness that if left untreated a severe risk of limitation futve problems. As to such is to further reduce pain, suffering & other health issues, concerns to reduce risks, problems. Estelle 429 us. 97 s. ct 285 50 L. Ed. 2d 251 (1979) As Plaintiff has documented medical issues & further concerns as to out side providers statements. Plaintiff slowly being seen, As to continued rescheduling. Bell v. Wolfish 411 U.S. 520 99 S. ct 1861 60 L.Ed.2d 477 (1979) [PL DOC #25]

Plaintiff's

Doc. H2

Plaintiff's,

medical kites - Responses H1 - H25

H20 medical letter stating further rescheduling.

Plaintiff has been on covid status since 6-16-22 after being on covid status in 2-2-22 Febuary. Plaintiff still being on covid status having over 9 negative test results

H25 states Plaintiff's health response issues as a concern from outside provider.

H26-31 Grievance responses -

H32-33 Last noted statement w/ medical kite.

Department of Corrections
WASHINGTON STATE

HEALTH SERVICES KITE

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used.

PLEASE PRINT ***SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY***

LAST NAME	FIRST NAME			
White Eagle	Jaomi			
DOC NUMBER	FACILITY	UNIT/CELL	DATE	TIME
255966	AHCC	RA63L	12/27/2021	9:10 pm
JOB/PROGRAM	JOB/PROGRAM HOURS	DAYS OFF		
NA				

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

☐ MEDICAL ☐ DENTAL ☒ MENTAL HEALTH

☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below

☐ OPTOMETRY ☐ OTHER: Head Psychologiest of AHCC

REASON FOR REQUEST (list problem or medications needing refill)

Last night at about 9:10 pm 12/26/2021, I was not feeling well From (physical medical illness) and yes Also Stress, due to non stop Harassments, Always was, and will Be, In WA D.O.C (all male Prisons) due to my being a Transexual Inmate in male population. So I had told my spouse with Lynn I felt like giveing up I did not state Like in Suicide, not at all, my GCS Surgery is all Aproved, IF I was said to be mentally unstable, That could

Ms. Naomi White Eagle
PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

☐ Schedule within ____ days/weeks/months ☐ Next available sick call ☐ No visit required

change, I Am very mentally Stable, I need my G.I.D Treatments, via Sergeroys ect It's A Life or Death medical need, I've Been Trying most my Life To transission call me in if you Question my mental State Please (I'm Stable, Fine) Thank you!

I have no concerns. Please let me know if you need anything. I will schedule you for follows up after Jan 1, 2022.

RESPONDER signature and stamp (all copies)	DATE and TIME
M. Holdway LMHC	12/29/21 10:45

Melisa Holdway, LMHC
Psychology Associate

Distribution: **WHITE/YELLOW** – Responder, **PINK** – Patient keeps
Distribution upon completion: **WHITE** – Health Record, **YELLOW** – Return to Patient with Response

Please declare a mental health emergency if having thoughts of suicide, self-harm or harm to others.

Department of Corrections WASHINGTON STATE

HEALTH SERVICES KITE

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used.

PLEASE PRINT ***SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY***

LAST NAME White Eagle		FIRST NAME Naomi		
DOC NUMBER 855986	FACILITY AHCC	UNIT/CELL K5 55 L	DATE 7/13/2022	TIME 3:07 pm
JOB/PROGRAM NA	JOB/PROGRAM HOURS		DAYS OFF	

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

☐ MEDICAL ☐ DENTAL ☒ MENTAL HEALTH

☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below

☐ OPTOMETRY ☐ OTHER: To Hadway - provider or psycologist

REASON FOR REQUEST (list problem or medications needing refill)

I Hear That AHCC Has a class For mental Helth issus and skill Bilding type tools - Drug-alcohal ect Haveing do in Some Regards To meditateing yoga type ect I Dont Have The name of this supposed MH skill ect class, I need To Be Inrolled in this class if possible, or what is to Be offered Here at AHCC, I Have changed 100% Turn around need Futher education's ect Tool's That will Be usefull in Helping my Success upon Release, Thank you!

Naomi White Eagle
PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

☐ Schedule within ____ days/weeks/months ☐ Next available sick call ☐ No visit required

We can discuss at your next session. Thank you for letting me know!

H2

M. Holdway

Melisa Holdway
Psychology Associate

RESPONDER signature and stamp (all copies)	DATE and TIME
[signature]	7/19/2022

Distribution: **WHITE/YELLOW** – Responder, **PINK** – Patient keeps

Distribution upon completion: **WHITE** – Health Record, **YELLOW** – Return to Patient with Response

H2

Department of Corrections
WASHINGTON STATE

HEALTH SERVICES KITE

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used.

PLEASE PRINT ***SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY***

LAST NAME	FIRST NAME		
White Eagle			
DOC NUMBER	FACILITY	UNIT/CELL	TIME
855788	AHCC	[illegible]	[illegible]
JOB/PROGRAM	JOB/PROGRAM HOURS	DAYS OFF	
N/A			

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

☐ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH

☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below

☐ OPTOMETRY ☐ OTHER: pharmacy

REASON FOR REQUEST (list problem or medications needing refill)

please Refill

Please Fast TRACT I have 6 days pills left I've not get The other card before This card run's out, it's a Antibiotic. Thank you.

Naomi White Eagle
PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

☐ Schedule within ____ days/weeks/months ☐ Next available sick call ☐ No visit required

Request is being processed for medication(s)
Medications take 7-10 days to process
Watch for Purple Pass

RESPONDER signature and stamp (all copies)	DATE and TIME
S. Page, LPN	JUL 20 2022

Distribution: **WHITE/YELLOW** – Responder, **PINK** – Patient keeps

Distribution upon completion: **WHITE** – Health Record, **YELLOW** – Return to Patient with Response

Department of Corrections
WASHINGTON STATE

HEALTH SERVICES KITE

This fill and print form is for healthcare staff to initiate communication with patients.
Patients are to use the 3-part NCR form to communicate with staff.

LAST NAME	FIRST NAME	
White Eagle	Naomi Sue	
DOC NUMBER	FACILITY	UNIT/CELL
855988	AHCC	RB352

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed in the patient's health record except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

TYPE OF RESPONSE

☐ MEDICAL ☐ DENTAL ☒ MENTAL HEALTH

☐ OPTOMETRY ☐ OTHER: _____

☐ Schedule within _____ days/weeks/months ☐ Next available sick call ☐ No visit required

Hello,

I am kiting you due to the current restricted movement schedule. I wanted to check in with you to see how you are doing. If you need anything from mental health at this time, please send me a kite.

If you need distraction material, please kite me listing what you would prefer. The following items are available:

Word Search
Crossword Puzzles
Dot to Dot
Coloring Pages (no pens, pencils, markers, or crayons available at this time)
Sudoku
Paper Chess
Paper Battleship
Relaxation/Meditation Scripts
Breathing/Relaxation Exercises
Anxiety Management Materials
Journaling Exercise (no composition books available at this time)

Thank you!
Melisa Holdway
Psychology Associate

RESPONDER typed name and signature	DATE
Melisa Holdway, Psychology Associate	**07/26/2022**

Distribution: **ORIGINAL** – Health Record **COPY** – Patient

MA-64-L

Department of Corrections WASHINGTON STATE

HEALTH SERVICES KITE

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used.

PLEASE PRINT ***SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY***

LAST NAME		FIRST NAME	
WHITE EAGLE		NAOMI	
DOC NUMBER: 855988	FACILITY: AHCC	UNIT/CELL: ~~MB35~~	DATE: 1/20/22	TIME: 1203 pm
JOB/PROGRAM: N/A	JOB/PROGRAM HOURS	DAYS OFF	

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

☑ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH

☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below

☐ OPTOMETRY ☐ OTHER: To; Dr. Paplic, Head of AHCC medical

REASON FOR REQUEST (list problem or medications needing refill)

Dr. Paplic, I'm having problems with my M.D provider Ms. Kathy Moore, she denies me any and all medical treatment having to do with my bowels - lower stomach (There is a very serious problem) I had H-pilyori infection, treatments failed to work ~~[illegible]~~ I'm in pain been in a lot of pain 7 months counting. I'm in need of medical care now, something has been over looked, Ms Moore refuses to even do Further testing, she dose not have a licence, she is not

Naomi White Eagle

PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

☐ Schedule within ____ days/weeks/months ☐ Next available sick call ☐ No visit required

A medical doctor, I'm now requesting that I not see Ms. Moore again and my provider be changed to some one else, Also I want a Licenced M.D treat this Real medical need,

Thank you,

Ms. Moore is a licensed prov. U.R. you see your provider based on your last name. You are scheduled for a colonoscopy in the future. Ms. Moore ordered it.

RESPONDER signature and stamp (all copies) [signature] DATE and TIME 1/27/22

Distribution: **WHITE/YELLOW** – Responder, **PINK** – Patient keeps

Distribution upon completion: **WHITE** – Health Record, **YELLOW** – Return to Patient with Response

I made a mistake & not feel up to rewriting. Thank you

MA642

Department of Corrections
WASHINGTON STATE

HEALTH SERVICES KITE

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used.

PLEASE PRINT ***SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY***

LAST NAME	FIRST NAME			
WHITE EAGLE	JARMI			
DOC NUMBER	FACILITY	UNIT/CELL	DATE	TIME
255988	AHCC	MA6 Low C	3/22	10:55 pm
JOB/PROGRAM	JOB/PROGRAM HOUR	DAYS OFF		
NO				

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

☒ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH

☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below

☐ OPTOMETRY ☐ OTHER: _____

REASON FOR REQUEST (list problem or medications needing refill)

To, Head of medical - ECT Dr. Pablo,
I saw a nurse checking vitals in M-A unit yesterday. I informed her I've been having upper respiratory - lungs pain started 3 days ago. I did test possitive covid on 1/24/2022, I've had pneumonia both Lungs, 3 different times, all needing Antibiotics. Last Date was 12-20-2021 time of Arrested if nearly died. The nurse said a medical provider would see me today.
Jarmi White Eagle
PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

☐ Schedule within ____ days/weeks/months ☐ Next available sick call ☐ No visit required

In my unit M-A, nobody came to follow up, the flu is over.
I did tell the nurse I've had breathing issues on my current MD provider & more, and I will not have her treat me. However I do need necessary medical care per policy - Laws would another provider treat me asap. Thank you.

RESPONDER signature and stamp (all copies) DATE and TIME

2/3/22

Distribution: **WHITE/YELLOW** – Responder, **PINK** – Patient keeps
Distribution upon completion: **WHITE** – Health Record, **YELLOW** – Return to Patient with Response

Department of Corrections WASHINGTON STATE

HEALTH SERVICES KITE

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used.

PLEASE PRINT ***SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY***

LAST NAME		FIRST NAME		
WHITE EAGLE		NAOMI		
DOC NUMBER	**FACILITY**	**UNIT/CELL**	**DATE**	**TIME**
855798	AHCC	MA031	3/8/2022	N/A
JOB/PROGRAM	**JOB/PROGRAM HOURS**		**DAYS OFF**	
N/A				

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

☒ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH

☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below

☐ OPTOMETRY ☐ OTHER: ________

REASON FOR REQUEST (list problem or medications needing refill)

Something is wrong with my Lower Abdmon causeing Severe pain Diarrih, and there is a clear milky white Substants in stool, [illegible] The substants is Somewhat like pus, could I be seen, please,

Thank you, Bless,

Ms Naomi Sue White Eagle

PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

☐ Schedule within ____ days/weeks/months ☐ Next available sick call ☐ No visit required

Seen in clinic 3/11/20. Work call out for f/u with pain provider. [illegible] wellness.

RESPONDER signature and stamp (all copies)	DATE and TIME
[illegible] RN	3/11/20 @ 1445

Distribution: **WHITE/YELLOW** – Responder, **PINK** – Patient keeps

Distribution upon completion: **WHITE** – Health Record, **YELLOW** – Return to Patient with Response

Department of Corrections WASHINGTON STATE

SMU MEDICAL KITE COPY **HEALTH SERVICES KITE**

MAY 2 2 2022

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used.

PLEASE PRINT ***SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY***

LAST NAME White Eagle			FIRST NAME NAomi	
DOC NUMBER 855988	FACILITY AHCC	UNIT/CELL RB33L SMU 5B03	DATE 5/21/2022	TIME 7:15 PM
JOB/PROGRAM N/A		JOB/PROGRAM HOURS	DAYS OFF	

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST **(check only one box per form)**

☒ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH

☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below

☐ OPTOMETRY ☐ OTHER: ________

REASON FOR REQUEST **(list problem or medications needing refill)**

I was ~~[illegible]~~ Supose to Have a collin ostapia due to my Foot geting Broke on 2/6/2022 this procedure was canceil Becauce I must Be wheight Bearing, well now Im walking with shoes (not a walking Cast) Fully weight Bearing on both Feet, Have I been given a new date to get this done or order what Ever you CAll it, AS my Bowells Have alot of pain Ect still gotten worse,

Thank you
Ms. Naomi white Eagle
PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

☐ Schedule within ____ days/weeks/months ☐ Next available sick call ☐ No visit required

Seen at cell front to assess and discuss current concerns re: abdominal pain. Julieann Ogaz RN2
"Sloppy watery stools"

It has been rescheduled. I just confirmed. They tested for H. Pylori with your EGD in May of last year (at least that's their usual practice)

RESPONDER signature and stamp (all copies) **S. Thompson, ARNP** [signature]
DATE and TIME 5-24-22

Distribution: **WHITE/YELLOW** – Responder, **PINK** – Patient keeps

Distribution upon completion: **WHITE** – Health Record, **YELLOW** – Return to Patient with Response

PATIENT COPY

HEALTH SERVICES UNIT
MAY 28 2022
AHCC

Department of Corrections
WASHINGTON STATE

HEALTH SERVICES KITE

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used.

PLEASE PRINT — *SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY*

LAST NAME	FIRST NAME			
White EAGLE	NAOMI			
DOC NUMBER	FACILITY	UNIT/CELL	DATE	TIME
855988	AHCC	N133C	5/27/2022	AM
JOB/PROGRAM	JOB/PROGRAM HOURS	DAYS OFF		
NO				

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

☒ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH

☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below

☐ OPTOMETRY ☐ OTHER: Josh Provider

REASON FOR REQUEST (list problem or medications needing refill)

was I to get the Stool sample test kite you said I'd get at our Appointment yesterday Before leaving medical, or how & when will I get them, As time keeps going Prolonging this issue & my pain discomforts

Thank you.

Naomi White Eagle
PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

☐ Schedule within ____ days/weeks/months ☐ Next available sick call ☐ No visit required

I believe you will be on call out to get this. Please let me know if this doesn't happen. Thanks

RESPONDER signature and stamp (all copies)	DATE and TIME
Landsverk, PA-C	5/31/22 0741

Distribution: WHITE/YELLOW – Responder, PINK – Patient keeps

Distribution upon completion: WHITE – Health Record, YELLOW – Return to Patient with Response

HQ

Department of Corrections
WASHINGTON STATE

HEALTH SERVICES KITE

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used.

PLEASE PRINT ***SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY***

LAST NAME			FIRST NAME	
ms. White Eagle			Naomi	
DOC NUMBER	**FACILITY**	**UNIT/CELL**	**DATE**	**TIME**
855988	AHCC	[illegible]	[illegible]/2022	[illegible]
JOB/PROGRAM	**JOB/PROGRAM HOURS**		**DAYS OFF**	

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

☐ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH

☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below

☐ OPTOMETRY ☐ OTHER: To Rpa Provider [illegible]

REASON FOR REQUEST (list problem or medications needing refill)

I'm feeling very weak with light headedness, very low energy (lower abdominal pain 24/7) going months now and now my breathing is difficult (heavy) something is very wrong. Something must be done asap I feel this on going/untreated medical need is life threatening, the delays past year of medical care. I need proper lab test pain asap. Thank you (my pain level is at about 5 to 10, up and down, ongoing, none stop, affecting all matters I must cope through. Thank you!

Ms. Naomi White Eagle
PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

☐ Schedule within ____ days/weeks/months ☐ Next available sick call ☐ No visit required

Patient will be scheduled for sick call with PCP next available time frame in PCP care schedule.

[signature]

RESPONDER signature and stamp (all copies)	DATE and TIME
[signature]	6/17/2022 @ 1555

Distribution: **WHITE/YELLOW** – Responder, **PINK** – Patient keeps

Distribution upon completion: **WHITE** – Health Record, **YELLOW** – Return to Patient with Response

H 10

Department of Corrections
WASHINGTON STATE

HEALTH SERVICES KITE

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used.

PLEASE PRINT ***SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY***

LAST NAME	FIRST NAME			
White Eagle	Naomi			
DOC NUMBER	FACILITY	UNIT/CELL	DATE	TIME
[illegible]	AHCC	[illegible]	7/17/2022	[illegible]
JOB/PROGRAM	JOB/PROGRAM HOURS	DAYS OFF		

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

☐ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH

☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below

☐ OPTOMETRY ☐ OTHER: Pharmacy

REASON FOR REQUEST (list problem or medications needing refill)

please refill

please first [illegible] I have [illegible]
I [illegible] the other care [illegible] this
card [illegible] out, it's a [illegible]. Thank you.

Naomi White Eagle
PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

☐ Schedule within ____ days/weeks/months ☐ Next available sick call ☐ No visit required

RESPONDER signature and stamp (all copies)	DATE and TIME

Distribution: **WHITE/YELLOW** – Responder, **PINK** – Patient keeps

Distribution upon completion: **WHITE** – Health Record, **YELLOW** – Return to Patient with Response

HIP

Department of Corrections
WASHINGTON STATE

HEALTH SERVICES KITE

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used.

PLEASE PRINT **SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY**

LAST NAME	FIRST NAME			
White Eagle	Naomi			
DOC NUMBER	FACILITY	UNIT/CF	DATE	TIME
855988	AHCC	RB	7/17/2022	2:26 pm
JOB/PROGRAM	JOB/PROGRAM HOURS		DAYS OFF	
NO				

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

☒ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH

☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below

☐ OPTOMETRY ☐ OTHER: To, Josh, provider,

REASON FOR REQUEST (list problem or medications needing refill)

Hi Josh, Thank you for the antibiotic metronidazole. However the doctor at the Spokane Hospital recommended 2 antibiotics be given, I only got this one? If another is needed along with this one I may not heal could you see into this issue. Also, I've had phew/vagina 3 times past, last two it took 6 weeks of antibiotics to heal it, stop it, some how with my health conditions, I'm told, so I'm unsertan 2 weeks-14 days of this metronidazole prescribed will work, Remember

Naomi White Eagle

PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

☐ Schedule within ____ days/weeks/months ☐ Next available sick call ☐ No visit required

I was treated with antibiotics 2 times of past starting over a year ago, Infection comming back both times, but I did not get 14 days supply only 11- and 9-, Thank you,

Forwarding to J. Landsverk for renewal review

JUL 18 2022

S. Hamby, LPN

This is the only antibiotic it was recommended.

RESPONDER signature and stamp (all copies) DATE and TIME

J. Landsverk, PA-C 7/18/22 0902

Distribution: **WHITE/YELLOW** – Responder, **PINK** – Patient keeps

Distribution upon completion: **WHITE** – Health Record, **YELLOW** – Return to Patient with Response

Department of Corrections
WASHINGTON STATE

HEALTH SERVICES KITE

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PLEASE PRINT ***SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY***

LAST NAME	FIRST NAME			
white eagle	Manny			
DOC NUMBER	FACILITY	UNIT/CELL	DATE	TIME
755488	AHCC	K055L	7/27/22	11
JOB/PROGRAM	JOB/PROGRAM HOURS	DAYS OFF		

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

☒ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH

☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below

☐ OPTOMETRY ☐ OTHER: To push - provide

REASON FOR REQUEST (list problem or medications needing refill)

I have been using the antibiotic metronidazole you prescribed as directed, two days left. Then 14 days is up you, I still do have symptoms of concern a discolored puss like substance in all bowel movements. Still, however I feel not much pain as before - no seen blood now, concern is will the 14 days be enough to kill all the infection is symptoms still exist. Thank you

Manny White Eagle
PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

☐ Schedule within ____ days/weeks/months ☐ Next available sick call ☐ No visit required

RESPONDER signature and stamp (all copies) | DATE and TIME

Distribution: **WHITE/YELLOW** – Responder, **PINK** – Patient keeps

Distribution upon completion: **WHITE** – Health Record, **YELLOW** – Return to Patient with Response

Department of Corrections
WASHINGTON STATE

HEALTH SERVICES KITE

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used.

PLEASE PRINT ***SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY***

LAST NAME	FIRST NAME			
White Eagle	NAOMI			
DOC NUMBER	FACILITY	UNIT/CELL	DATE	TIME
855988	AHCC	K235L	3/27/2022	6:00ish
JOB/PROGRAM	JOB/PROGRAM HOURS		DAYS OFF	

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

☒ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH

☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below

☐ OPTOMETRY ☐ OTHER: To Josh - provider

REASON FOR REQUEST (list problem or medications needing refill)

I Have been taking The antibiotic metroNIDAzole you prescribed As directed, Two days Left, then 14 days is up now, I still do Have Simptoms of Concern, a discolored puss Like Substance in all Bowel movements Still, However I Feel not much pain as befor - no seen Blood now, Concern is will the 14 days Suphy Be enough to kill all the infections Simptoms still Exist. Thank you

Naomi White Eagle
PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

☐ Schedule within ____ days/weeks/months ☐ Next available sick call ☐ No visit required

Current vitals. This duration was recommended per GI Make sure to stay hydrated, fiber and activity. This should help with GI health.

RESPONDER signature and stamp (all copies)	DATE and TIME
K. Landsverk, PA-C	4/18/22 0755

Distribution: **WHITE/YELLOW** – Responder, **PINK** – Patient keeps

Distribution upon completion: **WHITE** – Health Record, **YELLOW** – Return to Patient with Response

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

Department of Corrections
WASHINGTON STATE

"KITE" PARA SERVICIOS DE SALUD

Se usa este formulario para pedir servicios médicos no urgentes,
salvo en instituciones en donde se usa el quiosco u hoja en donde apuntar los nombres.

LETRA DE MOLDE, POR FAVOR

El pedir servicios de salud puede resultar en un copago.

APELLIDO	NOMBRE
White Eagle	NAOMI

NUMERO DE DOC	INSTITUCION	UNIDAD/CELDA	FECHA	HORA
358986	AHCC	MA03L	4/28/2021	8:27 pm

TRABAJO/PROGRAMA	TRABAJO/HORAS DEL PROGRAMA	DIAS LIBRES

Si piensa usted que tiene una emergencia médica de verdad, avise al personal y no use este formulario.

CLASE DE PETICION (marque sólo una casilla por formulario)

☑ MEDICA ☐ DENTAL ☐ SALUD MENTAL

☐ RESURTIDO DE MEDICAMENTOS – Apunte el/los medicamentos con el número o números de los medicamentos o pegue la etiqueta abajo.

☐ OPTOMETRIA ☐ OTRA: To; HSM-1 Kathleen o'connor

RAZON POR LA PETICION (explique el problema/apunte el medicamento del cual necesita un nuevo surtido)

Ms. o'connor, today 4/28 I kop kop winded issueables the nurse gave me the patient medication information sheet for Rx #7166171S, for Amoxicl-avulanate 875-125 mg TAB, However she did "NOT" give me the pill card of this medication, I STILL Have Recieved this, could you please Help me with this, and Thank you for the med's, I hope that this is Best to overall treat my needs. Thank you. Bless.
Ms. Naomi White Eagle

FIRMA DEL INTERNO

RESPUESTA DE SERVICIOS DE SALUD/CONSULTA

Se tiene que archivar este formulario si hay información abajo, con las siguientes excepciones: resurtidos de medicamentos, asuntos de dinero, cambios de trabajo/cama por razones no médicas, dietas religiosas, zapatos, clasificación, quejas acerca del personal, asuntos no relacionados con servicios médicos

☐Fije consulta dentro de ___ días/semanas/meses ☐Próxima llamada de enfermos ☐Consulta no requerida

Hello - There is no [illegible] medication prescribed to you in your chart or in the pharmacy tracking system. Please check the name of the medication you are looking for and let me know if you need further help with this.

PERSONA QUE RESPONDE firma y sello (todas las copias)	FECHA y HORA
K. O'Connor K. O'Connor, HSM1	4/29/2022

Distribución: **BLANCA/AMARILLA** – Persona que responde, **ROSA** – Interno/Interna

Distribución final: **BLANCA** – Archivo médico, **AMARILLA** – Se devuelve al interno con la respuesta

Rx Number: 71661715 **AMOX/CLAVULANATE 875-125MG TAB .**

ADDITIONAL INFORMATION: If your symptoms or health problems do not get better or if they become worse, call your doctor. Do not share your drugs with others and do not take anyone else's drugs. Some drugs may have another patient information leaflet. Check with your pharmacist. If you have any questions about this drug, please talk with your doctor, nurse, pharmacist, or other health care provider.

AMOX/CLAVULANATE 875-125MG PATIENT MEDICATION INFORM **Rx #71661715**

GENERIC NAME: Amoxicillin and Clavulanate Tablets (a moks i SIL in & klav yoo LAN ate)

COMMON USES: It is used to treat bacterial infections.

BEFORE USING THIS MEDICINE: WHAT DO I NEED TO TELL MY DOCTOR BEFORE I TAKE THIS DRUG? TELL YOUR DOCTOR: If you are allergic to this drug; any part of this drug; or any other drugs, foods, or substances. Tell your doctor about the allergy and what signs you had. TELL YOUR DOCTOR: If you are allergic to penicillin. TELL YOUR DOCTOR: If you have kidney disease. TELL YOUR DOCTOR: If you have turned yellow or had liver side effects with this drug before. TELL YOUR DOCTOR: If you have mono. TELL YOUR DOCTOR: If you are taking probenecid. This is not a list of all drugs or health problems that interact with this drug. Tell your doctor and pharmacist about all of your drugs (prescription or OTC, natural products, vitamins) and health problems. You must check to make sure that it is safe for you to take this drug with all of your drugs and health problems. Do not start, stop, or change the dose of any drug without checking with your doctor.

HOW TO USE THIS MEDICINE: HOW IS THIS DRUG BEST TAKEN? Use this drug as ordered by your doctor. Read all information given to you. Follow all instructions closely. Take with or without food. Take with food if it causes an upset stomach. Use as you have been told, even if your signs get better. HOW DO I STORE AND/OR THROW OUT THIS DRUG? Store at room temperature in a dry place. Do not store in a bathroom. Keep all drugs in a safe place. Keep all drugs out of the reach of children and pets. Throw away unused or expired drugs. Do not flush down a toilet or pour down a drain unless you are told to do so. Check with your pharmacist if you have questions about the best way to throw out drugs. There may be drug take-back programs in your area. WHAT DO I DO IF I MISS A DOSE? Take a missed dose as soon as you think about it. If it is close to the time for your next dose, skip the missed dose and go back to your normal time. Do not take 2 doses at the same time or extra doses.

CAUTIONS: Tell all of your health care providers that you take this drug. This includes your doctors, nurses, pharmacists, and dentists. Have your blood work checked if you are on this drug for a long time. Talk with your doctor. This drug may affect certain lab tests. Tell all of your health care providers and lab workers that you take this drug. If you have high blood sugar (diabetes) and test your urine glucose, talk with your doctor to find out which tests are best to use. Do not use longer than you have been told. A second infection may happen. Birth control pills and other hormone-based birth control may not work as well to prevent pregnancy. Use some other kind of birth control also like a condom when taking this drug. Tell your doctor if you are pregnant, plan on getting pregnant, or are breast-feeding. You will need to talk about the benefits and risks to you and the baby.

POSSIBLE SIDE EFFECTS: WHAT ARE SOME SIDE EFFECTS THAT I NEED TO CALL MY DOCTOR ABOUT RIGHT AWAY? WARNING/CAUTION: Even though it may be rare, some people may have very bad and sometimes deadly side effects when taking a drug. Tell your doctor or get medical help right away if you have any of the following signs or symptoms that may be related to a very bad side effect: Signs of an allergic reaction, like rash; hives; itching; red, swollen, blistered, or peeling skin with or without fever; wheezing; tightness in the chest or throat; trouble breathing, swallowing, or talking; unusual hoarseness; or swelling of the mouth, face, lips, tongue, or throat. Rarely, some allergic reactions have been deadly. Vaginal irritation. Diarrhea is common with antibiotics. Rarely, a severe form called C diff-associated diarrhea (CDAD) may happen. Sometimes, this has led to a deadly bowel problem. CDAD may happen during or a few months after taking antibiotics. Call your doctor right away if you have stomach pain, cramps, or very loose, watery, or bloody stools. Check with your doctor before treating diarrhea. Liver problems have happened with this drug. Rarely, this has been deadly. Call your doctor right away if you have signs of liver problems like dark urine, feeling tired, not hungry, upset stomach or stomach pain, light-colored stools, throwing up, or yellow skin or eyes. A severe skin reaction (Stevens-Johnson syndrome/toxic epidermal necrolysis) may happen. It can cause severe health problems that may not go away, and sometimes death. Get medical help right away if you have signs like red, swollen, blistered, or peeling skin (with or without fever); red or irritated eyes; or sores in your mouth, throat, nose, or eyes. WHAT ARE SOME OTHER SIDE EFFECTS OF THIS DRUG? All drugs may cause side effects. However, many people have no side effects or only have minor side effects. Call your doctor or get medical help if any of these side effects or any other side effects bother you or do not go away: For all patients taking this drug: Diarrhea, upset stomach, or throwing up. Children: Diaper rash. These are not all of the side effects that may occur. If you have questions about side effects, call your doctor. Call your doctor for medical advice about side effects. You may report side effects to the FDA at 1-800-332-1088. You may also report side effects at https://www.fda.gov/medwatch.

OVERDOSE: If you think there has been an overdose, call your poison control center or get medical care right away. Be ready to tell or show what was tal how much, and when it happened.

H 16

Department of Corrections
WASHINGTON STATE

HEALTH SERVICES KITE

This fill and print form is for healthcare staff to initiate communication with patients.
Patient offenders are to use the 3-part NCR form to communicate with staff.

LAST NAME	FIRST NAME	
Lowe "White Eagle"	**Lowell "Naomi"**	
DOC NUMBER **855988**	FACILITY **SCCC**	UNIT/CELL **IMU - FA20**

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, non-health services issues

TYPE OF RESPONSE

☒ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH

☐ OPTOMETRY ☐ OTHER: _____

☐ Schedule within _____ days/weeks/months ☐ Next available sick call ☐ No visit required

This is in response to your recent Public Disclosure request, #H9761. Regarding the evaluation that you requested, Dr. Cryder has told me that the evaluation needs to be reviewed with you before you can get a copy. I will keep this request open, so that when the evaluation is reviewed, I will copy and get a bill to you.

There are no kites in your medical file for the dates March 15th, 16th and 17th. Because they were written from the kiosk, they are probably in your central file.

RESPONDER typed name and signature	DATE
C. Flewelling, RHIT	**02/19/2021**

PRESCRIPTIONS MUST BE WRITTEN ON DOC 13-435 PRIMARY ENCOUNTER REPORT (PER) OR IN CIPS

Distribution: **ORIGINAL** – Health Record, **COPY** – Offender

State law (RCW 70.02) and/or federal regulations (42 CFR Part 2) prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

Metallic taste. Headache. Joint pain. Lowered interest in sex. These are not all of the side effects that may occur. If you have questions about side effects, call your doctor. Call your doctor for medical advice about side effects. You may report side effects to the FDA at 1-800-332-1088. You may also report side effects at https://www.fda.gov/medwatch.

OVERDOSE: If you think there has been an overdose, call your poison control center or get medical care right away. Be ready to tell or show what was taken, how much, and when it happened.

ADDITIONAL INFORMATION: If your symptoms or health problems do not get better or if they become worse, call your doctor. Do not share your drugs with others and do not take anyone else's drugs. Some drugs may have another patient information leaflet. Check with your pharmacist. If you have any questions about this drug, please talk with your doctor, nurse, pharmacist, or other health care provider.

METRONIDAZOLE 250MG TAB PATIENT MEDICATION INFORMATION Rx #71713997

GENERIC NAME: Metronidazole Tablets and Capsules (met roe NYE da zole)

WARNING: Metronidazole has been shown to cause cancer in mice and rats with long-term use. Talk with the doctor. The doctor has given you this drug for a certain health problem. Do not use this drug for other health problems. COMMON USES: It is used to treat infections. It may be given to you for other reasons. Talk with the doctor.

BEFORE USING THIS MEDICINE: WHAT DO I NEED TO TELL MY DOCTOR BEFORE I TAKE THIS DRUG? TELL YOUR DOCTOR: If you are allergic to this drug; any part of this drug; or any other drugs, foods, or substances. Tell your doctor about the allergy and what signs you had. TELL YOUR DOCTOR: If you have Cockayne syndrome. Some people with Cockayne syndrome have had liver problems when taking this drug. Sometimes, these liver problems have not gone away or have been deadly. TELL YOUR DOCTOR: If you have taken disulfiram within the past 2 weeks. TELL YOUR DOCTOR: If you are less than 12 weeks pregnant. This drug is not for use in certain patients who are less than 12 weeks pregnant. TELL YOUR DOCTOR: If you are breast-feeding. Do not breast-feed for 24 hours after getting this drug. This is not a list of all drugs or health problems that interact with this drug. Tell your doctor and pharmacist about all of your drugs (prescription or OTC, natural products, vitamins) and health problems. You must check to make sure that it is safe for you to take this drug with all of your drugs and health problems. Do not start, stop, or change the dose of any drug without checking with your doctor.

HOW TO USE THIS MEDICINE: HOW IS THIS DRUG BEST TAKEN? Use this drug as ordered by your doctor. Read all information given to you. Follow all instructions closely. Take with or without food. Take with food if it causes an upset stomach. Keep taking this drug as you have been told by your doctor or other health care provider, even if you feel well. HOW DO I STORE AND/OR THROW OUT THIS DRUG? Store at room temperature protected from light. Store in a dry place. Do not store in a bathroom. Keep all drugs in a safe place. Keep all drugs out of the reach of children and pets. Throw away unused or expired drugs. Do not flush down a toilet or pour down a drain unless you are told to do so. Check with your pharmacist if you have questions about the best way to throw out drugs. There may be drug take-back programs in your area. WHAT DO I DO IF I MISS A DOSE? Take a missed dose as soon as you think about it. If it is close to the time for your next dose, skip the missed dose and go back to your normal time. Do not take 2 doses at the same time or extra doses.

CAUTIONS: Tell all of your health care providers that you take this drug. This includes your doctors, nurses, pharmacists, and dentists. Have blood work checked as you have been told by the doctor. Talk with the doctor. This drug may affect certain lab tests. Tell all of your health care providers and lab workers that you take this drug. If you are on dialysis, talk with your doctor. Avoid alcohol and products that have alcohol or propylene glycol in them while taking this drug and for at least 72 hours after your last dose. Drinking alcohol or taking products that have alcohol or propylene glycol in them, like some cough syrups, may cause stomach cramps, upset stomach or throwing up, headaches, and flushing. Do not use longer than you have been told. A second infection may happen. If you are 65 or older, use this drug with care. You could have more side effects. Tell your doctor if you are pregnant or plan on getting pregnant. You will need to talk about the benefits and risks of using this drug while you are pregnant.

POSSIBLE SIDE EFFECTS: WHAT ARE SOME SIDE EFFECTS THAT I NEED TO CALL MY DOCTOR ABOUT RIGHT AWAY? WARNING/CAUTION: Even though it may be rare, some people may have very bad and sometimes deadly side effects when taking a drug. Tell your doctor or get medical help right away if you have any of the following signs or symptoms that may be related to a very bad side effect: Signs of an allergic reaction, like rash; hives; itching; red, swollen, blistered, or peeling skin with or without fever; wheezing; tightness in the chest or throat; trouble breathing, swallowing, or talking; unusual hoarseness; or swelling of the mouth, face, lips, tongue, or throat. Signs of a very bad skin reaction (Stevens-Johnson syndrome/toxic epidermal necrolysis) like red, swollen, blistered, or peeling skin (with or without fever); red or irritated eyes; or sores in the mouth, throat, nose, or eyes. Redness or white patches in mouth or throat. Vaginal itching or discharge. Fast or abnormal heartbeat. Pain when passing urine or blood in urine. Passing urine more often. Pelvic pain. Nervous system problems have happened with this drug. Some people who took this drug for a long time have had nerve problems that lasted for a long time. Call your doctor right away if you have a burning, numbness, or tingling feeling that is not normal; change in balance or eyesight; dizziness or passing out; headache; not able to sleep; seizures; or trouble speaking. Call your doctor right away if you feel confused, depressed, irritable, tired, or weak. This drug may raise the chance of a very bad brain problem called aseptic meningitis. Call your doctor right away if you have a headache, fever, chills, very upset stomach or throwing up, stiff neck, rash, bright lights bother your eyes, feeling sleepy, or feeling confused. Low white blood cell counts have happened with this drug. This may lead to a higher chance of getting an infection. Call your doctor right away if you have signs of infection like fever, chills, or sore throat. WHAT ARE SOME OTHER SIDE EFFECTS OF THIS DRUG? All drugs may cause side effects. However, many people have no side effects or only have minor side effects. Call your doctor or get medical help if any of these side effects or any other side effects bother you or do not go away: Constipation, diarrhea, stomach pain, upset stomach, throwing up, or feeling less hungry. Stomach cramps.

#10 LASH 18

Department of Corrections
WASHINGTON STATE

OFFENDER I.D. DATA: WHITE EAGLE, Naomi S.
(Name, DOC#, DOB) 855988 1962

CARE REVIEW COMMITTEE REPORT

DATE:	CONSULT ID:	INSTITUTION:	ERD:
11/30/2021	130909	AHCC	9/22/2027

PRIMARY CARE PRACTITIONER:	ATTENDING PHYSICIAN:	CASE PRESENTED BY:
,	Burt, Nathaniel B.	Burt, Nathaniel B.

Case Synopsis/Differential or Working Diagnosis:
see MER in chart

Intervention Proposed:
GD CRC consult to "review external consultant assessment for surgery"

Committee Recommendations:
Level 1

Recommendation Legend: Level I – Approved As Medically Necessary Level III – Not Approved: Not Medically Necessary

End Date of Approval (if indicated):

Voting Members Present:
DR. Samir Aziz, Dr. F. Longano

PRACTITIONER SIGNATURE:

Burt, Nathaniel B.

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
AIRWAY HEIGHTS CORRECTIONS CENTER
P.O. Box 1899 • Airway Heights, Washington 99001-1899 • (509) 244-6700
FAX (509) 244-6710

June 15, 2022

Ms. Naomi White Eagle
DOC 855988 AHCC ~~SB03L~~ RB09L
P.O. Box 1899
Airway Heights, WA 99001

Dear Ms. White Eagle,

I am writing in response to a recent letter of concern you wrote that was received by the Department's Correspondence Unit on June 1, 2022 (DEP-66513). Your concern, regarding an untreated infection, was assigned to me for review. I have looked into your case and, via health record review and discussion with the Facility Medical Director, this is what I learned.

You were treated for H. Pylori in March of 2021. Since then you have had an EGD with a biopsy, the results of which were negative for H. Pylori. Please note that repeat lab testing is not recommended, as results may remain positive even after treatment. You have been seen several times since as a result of your apparent belief that you have a bowel infection. Extensive test results have however been negative.

You have reported intestinal issues and diarrhea and have received appropriate medical workups for those concerns. A colonoscopy was requested, approved and scheduled but unfortunately had to be cancelled recently, due to your Living Unit then being on Quarantine status. The procedure has been rescheduled and you are asked to remain as patient as possible in this regard.

Your health is important to us, and you are in the care of committed and competent providers. Please continue to report new or worsening symptoms, if and as they occur, so that any new information can be considered by your provider team.

Sincerely,

Don McIntyre, AHCC Health Service Manager
Cc: David Flynn, DOC Assistant Secretary-Health Services

H20

PATIENT COPY

Department of Corrections
WASHINGTON STATE

HEALTH SERVICES KITE

This fill and print form is for healthcare staff to initiate communication with patients.
Patients are to use the 3-part NCR form to communicate with staff.

LAST NAME	FIRST NAME	
White Eagle	Naomi	
DOC NUMBER	FACILITY	UNIT/CELL
855988	AHCC	R809

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed in the patient's health record except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, non-health services issues

TYPE OF RESPONSE

☒ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH

☐ OPTOMETRY ☐ OTHER: _____

☐ Schedule within _____ days/weeks/months ☐ Next available sick call ☐ No visit required

Ms. White Eagle,

Your recent lab tests were negative for H. pylori and c.diff. We will continue with colonoscopy as scheduled. when!

RESPONDER typed name and signature
J. Landsverk, PA-C

DATE
06/08/2022

Distribution: **ORIGINAL** – Health Record **COPY** – Patient

Department of Corrections WASHINGTON STATE

Follow up

HEALTH SERVICES UNIT JUN 12 2022

PATIENT COPY

HEALTH SERVICES KITE

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used. AHCC

PLEASE PRINT

SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY

LAST NAME	FIRST NAME			
White Eagle	NAOMI			
DOC NUMBER	FACILITY	UNIT/CELL	DATE	TIME
855988	AHCC	RB09-L	6/11/2022	7:38 AM
JOB/PROGRAM	JOB/PROGRAM HOURS	DAYS OFF		
N/A				

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

☒ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH

☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below

☐ OPTOMETRY ☐ ~~OTHER~~: To Josh, my provider

REASON FOR REQUEST (list problem or medications needing refill)

I am scheduled for a colonoscopy, however which is a medical necessity need to try and figure out why I am in so much adominal pain and bacteria infection. This medical illness hinders my daily activities, and it's difficult walking Even, due to pain, I must have all test Ran to find problem, this issue must be resolved please resolve it in a timely matter, I get dizzy spells, very tired, low Energy, weakened Thank you

Naomi White Eagle

PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

☐ Schedule within ____ days/weeks/months ☐ Next available sick call ☐ No visit required

The colonoscopy will help provide more diagnostics. Recent labs were normal. Consider increasing fiber and hydration in diet

RESPONDER signature and stamp (all copies)	DATE and TIME
J. Landsverk, PA-C	6/13/22 1342

Distribution: WHITE/YELLOW – Responder, PINK – Patient keeps

Distribution upon completion: WHITE – Health Record, YELLOW – Return to Patient with Response

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

DOC 13-423 (01/13/2022) DOC 610.600 DOC 610.650 DOC 630.500 DOC 630.540 DOC 650.020 KITES

H22

RA 4B PATIENT COPY

SMU/SB11 HEALTH SERVICES UNIT INF/IB091

JUN 16 2022

AHCC

Department of Corrections WASHINGTON STATE

HEALTH SERVICES KITE

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used.

PLEASE PRINT *SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY*

LAST NAME	FIRST NAME			
White Eagle	[illegible]			
DOC NUMBER	FACILITY	UNIT/CELL	DATE	TIME
855988	AHCC	[illegible]	6/15/2022	Noon
JOB/PROGRAM	JOB/PROGRAM HOURS	DAYS OFF		
N/A				

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

☑ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH

☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below

☐ OPTOMETRY ☐ OTHER: Provider - Josh

REASON FOR REQUEST (list problem or medications needing refill)

I was wondering As the follow up note said scheduling for Colonoscopy & other testings for intestinal - bacteria infection.

Ms. Naomi Sue White Eagle

PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

☐ Schedule within ____ days/weeks/months ☐ Next available sick call ☐ No visit required

You have been scheduled for Colonoscopy. No other tests are needed at this time.

RESPONDER signature and stamp (all copies)	DATE and TIME
J. Lamisvark, PA-C	6/16/22 0720

Distribution: WHITE/YELLOW – Responder, PINK – Patient keeps

Distribution upon completion: WHITE – Health Record, YELLOW – Return to Patient with Response

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

DOC 13-423 (01/13/2022) DOC 610.600 DOC 610.650 DOC 630.500 DOC 630.540 DOC 650.020 KITES

H 23

HEALTH SERVICES UNIT
JUL 12 2022
AHCC

PATIENT COPY

Department of Corrections
WASHINGTON STATE

HEALTH SERVICES KITE

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used.

PLEASE PRINT — *SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY*

LAST NAME	FIRST NAME			
White Eagle	Naomi			
DOC NUMBER	FACILITY	CELL	DATE	TIME
855988	AHCC	35-L	7/11/2022	5:30 pm
JOB/PROGRAM	JOB/PRO	HOURS	DAYS OFF	
NO				

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

☒ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH

☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below

☐ OPTOMETRY ☐ ~~OTHER:~~ To Josh, my Provider

REASON FOR REQUEST (list problem or medications needing refill)

I Had a Colon ostipiey at a Spokan Hospital — medical center, a few weeks BACK, the Doctor who dont it recommended 2 Antibiotics which I Have not yet Started would you please look into This matter & start them

Thank you

Naomi White Eagle
PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

☐ Schedule within ____ days/weeks/months ☐ Next available sick call ☐ No visit required

They stated "Consider" antibiotic.
I will look into this again

RESPONDER signature and stamp (all copies) — DATE and TIME 7/12/22 0715

H24

Distribution: WHITE/YELLOW – Responder, PINK – Patient keeps

Distribution upon completion: WHITE – Health Record, YELLOW – Return to Patient with Response

Department of Corrections
WASHINGTON STATE

PATIENT COPY
HEALTH SERVICES KITE
PATIENT COPY

This fill and print form is for healthcare staff to initiate communication with patients.
Patients are to use the 3-part NCR form to communicate with staff.

LAST NAME	FIRST NAME	
White Eagle	Naomi	
DOC NUMBER	FACILITY	UNIT/CELL
855988	AHCC	R B35

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed in the patient's health record except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

TYPE OF RESPONSE

☒ MEDICAL ☐ DENTAL ☐ MENTAL HEALTH
☐ OPTOMETRY ☐ OTHER: _____

☐ Schedule within _____ days/weeks/months ☐ Next available sick call ☐ No visit required

Ms. White Eagle,

Your chest CT on 7/18/22 showed small nodule. The radiologist suspects this is benign or noncancerous but would like to repeat study in 6 months to evaluate trending. This study has been requested. If you have any questions, please let me know. Thanks.

RESPONDER typed name and signature	DATE
J. Landsverk, PA-C	08/01/2022

Distribution: **ORIGINAL** – Health Record **COPY** – Patient

Department of Corrections WASHINGTON STATE

RESOLUTION REQUEST

LOG ID NUMBER: 22754536

Facility/office received	Date/time received
AHCC Resolutions	4/22/22 1200

Check one: Include Log ID number for appeal or rewrite

☒ Initial ☐ Health Services ☐ Emergency ☐ Appeal ☐ Rewrite

Last name	First	Middle initial	DOC number
White Eagle	Naomi	S	855988

Facility/office	Unit/cell
AHCC	MA03L

Location	Date of incident	Time
M-Unit, A Side	4/20/2022	10:45 AM

Witness name(s) and DOC number (if relevant):

Who (names) and/or what (policy, procedures, or practice) are you submitting your concern about?

DOC personnal's in comand, Personnel saffty

Provide a short description of what happened and how it affected you:

On about 4/18/2022 I became awear that the chemical's what is being used as a Hepestat To Fight covid was burning my lungs - eyes, causeing caughing, and lung pain, Even wSeing Face mask, To day wseing a cloth and Face mask combined, The ordr or Chemicals is having a nesitive ~~Effect~~ efect causeing the same Efects in my lungs & eyes, I ts strongest in Bathroom near 1 Cell A Side, wen I was just told By a Inmate that Bleach and Hepestat is being mixed togather, Basic chemistry to mix them creates a New chemical, I feel my personna Health-saffty is at Risk, I can tast it Even in my cell door closed + mixing chemicals can Even cause death!!

Suggested remedy: Teach people who Instruct workers what mixing Chemical's dose create, This matter must be Addressed now!

Signature (Required): Naomi S White Eagle Date: 4/20/2022

Resolution Specialist Response

- ☐ Formal concern/appeal paperwork is being prepared
- ☐ Request is not accepted per the Resolution Program Manual
- ☐ You requested to withdraw the concern
- ☐ Additional information and/or rewrite needed. Return by: _____
- ☐ No rewrite received. Resolution Specialist withdrawal on: _____
- ☐ Sent to _____ on _____
- ☐ Correspondence
- ☐ Administratively withdrawn
- ☒ Informal resolution attempt
- ☐ Received from _____ on _____

Comments:

I appreciate your concern. Please send a kite to medical requesting an appointment w/ your PCP to discuss these health concerns.

Tim Taylor
Resolution Specialist

Signature

4/22/22
Date

H25B

Statements Conclusion of Grievances

Purpose of a grievance is to make officials awace of issues, misconduct to seek remedy unto & by officials. As to prisoners unto policy 550.100, 310.100, 100.500 WAC: 137-28-285 Also see purpose of Grievances Johnson v. Johnson 385 f.3d 503, 522 (5th cir) U.S. v. Powell 564 f.2d 256 98 1449, 1435 U.S. 904 55 61 142) Bradheim v. cry 584 f.3d 1262, 1296)

Defendant's violated such As to Due Process Imposing limitations & Depriving Plaintiff The Equal Protection of policies & laws. RCW: 72.01.060, 43.01.125 Also see; Dent v. west virginia 129 U.S 114 9 sup ct. 231 the 14th Amendment of the constitution. In deciding that "No State" shall deny ANY Person within It's Jurisdiction the Equal protection of the law; "which defendants: Plainly & clearly did." cause limitations upon the exercise of all the powers of the state. which can touch the individual or his/her property. * whatever the state may do It CANNOT deprive anyone with It's Jurisdiction the equal protection of the laws. And Equal Protection of the laws is meant "Equal security" under them to everyone under similar Terms. (The Prevention from wrengs & like circumstances. Due Process) Windsor v. mcveigh 93 U.S. 274, 277) Helling v. McKinney 509 U.S. 25 125 L.Ed 2d 22 113 S. ct 2475) Defendants knew & know of issues unto medical, giving & causing unneeded pain & stress by same/similar responses & is violative of Rcw: 51.24.020, 49.60.030, 29.02 Also see, Soneeya v. Spencer 851 f.supp. 2d 228, 248) & Jett v. Penner 439 f.3d 1091, 1096 (9th cir) also further Foulk v. charrier 262 f.3d 687, 698)

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AHCC

Department of Corrections
WASHINGTON STATE

HEALTH SERVICES KITE

This fill and print form is for healthcare staff to initiate communication with patients.
Patients are to use the 3-part NCR form to communicate with staff.

LAST NAME	White Eagle (Lowe)	FIRST NAME	Naomi (Lowell)
DOC NUMBER	855988	FACILITY	~~SCCC~~ AHCC
UNIT/CELL	~~FNA07~~ R-A-63L		

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed in the patient's health record except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, non-health services issues

TYPE OF RESPONSE

☐ MEDICAL ☐ DENTAL ☒ MENTAL HEALTH
☐ OPTOMETRY ☒ OTHER: Dr. Cryder

☐ Schedule within _____ days/weeks/months ☐ Next available sick call ☒ No visit required

Ms. White Eagle - first, I am sorry for the delayed response. I have been on vacation since March 19 and just returned today.

With grievances, there are 4 levels.

L0 - informal review and fixed at the lowest level

L1 - what is typically thought of as a grievance. If it is not responded to in a timely manner, it is escalated to a L2. Or if you are not happy with the response from L1, then it is appealed to L2.

L2 - means it is escalated to a higher authority within the facility. For example, I handle both L1 and L2 grievances because I am the Psych 4. You can appeal a L2 decision to L3.

L3 - this level means it is taken to HQ to review and respond.

What the grievance coordinator did on your behalf was to elevate your grievance because whoever was assigned your grievance did not respond in a timely fashion. It does not impact your sentencing or have anything to do with you. The coordinator is helping to move your grievance to a higher level of review.

I hope that helps.

C. Cryder, PhD

Department of Corrections
WASHINGTON STATE

RESOLUTION REQUEST

LOG ID NUMBER: 22753297

Facility/office received: AHCC Resolutions

Date/time received: APR 05 2022

Check one: Include Log ID number for appeal or rewrite

☐ Initial ☒ Health Services ☒ Emergency ☐ Appeal ☐ Rewrite

Last name	First	Middle initial	DOC number
WHITE EAGLE	NAOMI	SUE	855985

Facility/office	Unit/cell
AHCC	MA036

Location	Date of incident	Time
AHCC	3/30/2022 to 4/5/2022	

Witness name(s) and DOC number (if relevant):

Who (names) and/or what (policy, procedures, or practice) are you submitting your concern about?

Doc medical personnal's & c/o's, names unknown, Delayed medical care

Provide a short description of what happened and how it affected you:

on 3/30/22 top line was shut down Befor getting my meds, Also Each and Every top pick up time's to Date has been Either shout down or not called for me not Alowe ing me to pick up my past Ready top's, this Delay is, and has been causeing me Severe Stomach pain, The medication is to Help if not Be painfull, my Grievance an Emergency due to fact Severe pain is ongoing with out this medication's, I wrote Emital med kite that I was out, so it's mown, Thank you!

Suggested remedy:

Phase Allow me Some How or way get my medications, As Apo, To stop my pain Thank you

Signature (Required): Ms. Naomi Sue White Eagle Date: 4/3/2022

Resolution Specialist Response

☐ Formal concern/appeal paperwork is being prepared
☐ Request is not accepted per the Resolution Program Manual
☐ You requested to withdraw the concern
☐ Additional information and/or rewrite needed. Return by: _____
☐ No rewrite received. Resolution Specialist withdrawal on: _____
☐ Sent to _____ on _____
☐ Correspondence
☐ Administratively withdrawn
☐ Informal resolution attempt
☐ Received from _____ on _____

Comments:

Please note, your complaint is **not** a potentially serious threat to the life or health of an individual, related to severe pain, or an issue that involves a potential threat to the orderly operation of the facility. This complaint will be forwarded to the Resolution Dep and processed as routine.

Date: 4/3/22
Time received: 1430
Time answered: 1457
Staff Name: C. Bouscher, RN3

Nursing Supervisors are aware of the issue, and the process is being reviewed.

Tim Taylor
Resolution Specialist

Signature

4/7/22
Date

Medical Resolution Request

Department of Corrections
WASHINGTON STATE

RESOLUTION REQUEST

LOG ID NUMBER:	
Facility/office received	Date/time received
AHCC	6/27/21 1045

Include Log ID number for appeal or rewrite

Check one:

☐ Initial ☒ Emergency ☐ Appeal ☐ Rewrite

Last name	First	Middle initial	DOC number
White Eagle AKA Lowe	Naomi Lowell	S	855988

Facility/office	Unit/cell
AHCC	RA63-L

Location	Date of incident	Time
AHCC	Started 5/15/2021	N/A

Witness name(s) and DOC number (if relevant):

Who (names) and/or what (policy, procedures, or practice) are you submitting your concern about?
John Jain Does DOC Personnel - my provider
The practice of medical care Inadequacy and or Negligence.

Provide a short description of what happened and how it affected you:
My complaint is starting Befor or about 5/15/2021 I Submitted a medical Health Kites Reporting Bowells pain - Lower abdominal stomach" I was treated For this over the past 8 months Three Failed Attempts to Date. While Housed at SCCC I Requested a street Doctor, I was seen at Spokane Hospital on 5/21/2021, He done a Scope "upper stomach" By D.O.C Doctors Request. this Doctor told me I had a Infection "verbley" H- pholorria D.O.C Health Care says He did not say this, and I do not Have H- pholorria, However SCCC Doctor young found and treated Some kind of Infection - 3 times, the Infection came Back Each time, I Have Lower abdominal pain in my Bowells Again, with constant Diarrhea, a Infection is - like threating untreated. Stop Ignoring my needs stop Negligence By Seeing me and treating my medical needs! I Request to Be Examind and treated By a Licened M.D Doctor who stands Behind oaths of medical licenec WA

Suggested remedy:

Signature (Required): Naomi Sue White Eagle Date: 6/27/2021

Resolution Specialist Response

☐ Formal concern/appeal paperwork is being prepared
☒ Request is not accepted per the Resolution Program Manual
☐ You requested to withdraw the concern
☐ Additional information and/or rewrite needed. Return by: _____
☐ No rewrite received. Resolution Specialist withdrawal on: _____
☐ Sent to _____ on _____
☐ Correspondence
☐ Administratively withdrawn
☐ Informal resolution attempt
☐ Received from _____ on _____

Comments:

Please note, your complaint is not a potentially serious threat to the life or health of an individual, related to severe pain, or an issue that involves a potential threat to the orderly operation of the facility. This complaint will be processed as a routine complaint.

This is a chronic issue that has been ongoing and that has been addressed by your provider - Kite dated 5/31/21 was sent back showing specialist H-pylori test (-) negative - your provider has been diligent to follow-up with your requests - Watch Collect Jillieann Opatz

6.27.2021

Resolution Specialist J. Opatz, RN2 Signature Date

Department of Corrections
WASHINGTON STATE

LOG ID NUMBER
21732245

LEVEL I RESOLUTION RESPONSE

Last name	First	Middle	DOC number
Lowe (White Eagle)	Lowell (Naomi)	Gene (Sue)	855988

Facility/office: AHCC | Unit/cell: RA63L

PART A – INITIAL CONCERN Date typed: 7/7/21 Date due: 7/28/21

My concern is (who and/or what): DOC personnel, John/Jane Doe's of Medical delayed medical care

Location: AHCC | Date of incident: 5/21/21 to date | Time: N/A

Witness(es): N/A

Description:
I was treated at the street hospital on 5/21/2021. They did a scope in my stomach and found a type of infection. Something like "H. Pylori" or something. After he was done, the hospital doctor showed me photos and told me that I have this infection in my stomach and intestines. He said that he prescribed antibiotics and that Medical at AHCC would start them right away. Days have passed and I have not gotten any antibiotics at all yet. My abdominal bowels are causing me a lot of pain with diarrhea. I've been treated for this same infection 3 times by DOC before this. Nothing worked. I've had this infection for 7 months. So I now grieve this issue. Thank you.

Suggested remedy:

/s/ Naomi White Eagle — Requestor's signature — 5/29/21 — Date

CS2 Patrick Strand — Resolution Specialist — /s/ P. Strand — Signature — 7/7/21 — Date

PART B – LEVEL I RESPONSE

Your Level 1 resolution concerning not being prescribed an antibiotic to treat H. pylori infection was reviewed by J. Michaelis, RN, CS2. The chart was reviewed; in March 2021, H. pylori test was positive. However, in May, 2021, the patient underwent a gastroesophagoduodenoscopy (aka EGD) which included obtaining a tissue sample specifically to test for H. pylori. The test results this time were negative. On 06/14/21, her practitioner, Kathryn Moore, PA-C, sent a copy of the test results to the patient.

If you have misplaced your copy, send a kite to Health Services Medical Records to request a duplicate.

Since the test was negative no antibiotic prescription is necessary or warranted.

J Michaelis, RN, CS2 — Resolution Specialist — J Michaelis RN, CS2 — Signature — 09/27/2021 — Date

You may appeal this response by submitting a written appeal to the Resolution Specialist within 5 working days from date this response was received.

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.

Distribution: **ORIGINAL** - Resolution Program Manager **COPY** - Resolution Specialist, Individual

Department of Corrections
WASHINGTON STATE

LOG ID NUMBER
21733848

LEVEL I RESOLUTION RESPONSE

Last name	First	Middle	DOC number
Lowe	Lowell		855988

Facility/office: AHCC | Unit/cell: RA63L

PART A – INITIAL CONCERN Date typed: 7/30/21 Date due: 8/20/21

My concern is (who and/or what): DOC personnel - my provider - The practice of medical care inadequacy and/or negligence!

Location: AHCC | Date of incident: 7/30/21 | Time:

Witness(es):

Description:
My complaint is starting before or about 5/15/2021. I submitted medical health kites reporting bowel pain - 'lower abdomen/stomach." I was treated for this over the past 8 months, "three failed attempts to date." While housed at SCCC, I requested a street doctor. I was seen at a hospital in Spokane on 5/21/2021. He did an "upper stomach" scope by DOC doctor's request. This doctor verbally told me I had an infection, H. pylori. DOC health care says he did not say this, and I do not have H. pylori. However, SCCC Doctor Young found and treated some kind of infection - 3 times! The infection came back each time. I have lower abdominal pain in my bowels again with constant diarrhea. Infection is life-threatening if left untreated. Stop ignoring my needs.

Suggested remedy:
Stop the negligence by seeing me and treating my medical needs! I request to be examined and treated by a licensed MD doctor who stands behind oaths of medical license in WA.

/s/ Lowell Lowe — Requestor's signature
7/30/21 — Date

CS2 Patrick Strand — Resolution Specialist
/s/ P. Strand — Signature
8/20/21 — Date

PART B – LEVEL I RESPONSE

Resolution Specialist | Signature | Date

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Plaintiff lastly adds & states following defendant(s) Holdaway continued reschedulings & mistakes unto error, causing a hindecance cancelling appointment after appointment, furthering the pain & suffering / discomfuct of Plaintiff which is violative of medical standards, procedures & practices. WAC: 137-91-010 RCW: 43.19.003, 29A.56.110 Scott 110 wn.2d 682, 686 757 P.2d 492) And violative of such as to RCW: 29.09.009 For medical officials are to treat all properly & of the same. Failing to do so as stated is violative of proper & Adequate medical care/ treatment. Allard V. Gomez 9 Fed. App. 793 (9th cir) Helling V. McKinney 509 U.S. 25 125 L.Ed.2d 22, 113 S. Ct 2475) Plaintiff states as to all here in that respectfully said court will find this Amended complaint favorable. Plaintiff being a lay person and not a attorney have no law of court filing experience. that said complaint passes said screening & qualifies as a complaint. Having stated as to who, what, how, why as to statements & deficientcies asked by said court. Plaintiff working at her best ability as a lay person. Also see (PL-DOC H2) H25 H25 B) as to concern cause / issues...

Respectfully,

Submitted. this 22 day of Aug 2022

MS. Naomi Sue White Eagle

Naomi Sue White Eagle

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Department of Corrections
WASHINGTON STATE

HEALTH SERVICES KITE

This form must be used to request non-emergency healthcare services, except in facilities where kiosks or sign-up sheets are used.

PLEASE PRINT ***SUBMISSION OF HEALTH SERVICES REQUEST MAY RESULT IN A CO-PAY***

LAST NAME: White Eagle			FIRST NAME: NAOMI	
DOC NUMBER: 825482	FACILITY: AHCC	UNIT/CELL: MA03L	DATE: 4-4-2022	TIME: 9:49 AM
JOB/PROGRAM: N/A		JOB/PROGRAM HOURS		DAYS OFF

If you feel you have an actual medical emergency, alert the staff and do not use this form.

TYPE OF REQUEST (check only one box per form)

☐ MEDICAL ☐ DENTAL ☒ MENTAL HEALTH

☐ MEDICATION REFILL – List medication(s) with prescription number(s) or place sticker below

☐ OPTOMETRY ☐ OTHER: TO MS. HOLDWAY

REASON FOR REQUEST (list problem or medications needing refill)

MS. Holdway my 9/1 appointment - call out was canceled today, was it Dr. Staller and why was it cancele. If NOT Dr. Staller what was it, will it Be rescheduled

Thank you

Ms. Naomi White Eagle
PATIENT SIGNATURE

HEALTH SERVICES RESPONSE/ENCOUNTER

This form must be filed if any information is entered below except for: simple prescription refills, finance, non-medical work/bunk change, religious diets, shoes, classification, complaints about staff, non-health services issues

☐ Schedule within ____ days/weeks/months ☐ Next available sick call ☐ No visit required

No, the appointment was not with Dr. Staller. It was an appointment made in error with a new Psych associate. I canceled it and rescheduled you with me. Everything is fine, it was a mistake on the schedule.

RESPONDER signature and stamp (all copies)	DATE and TIME
[illegible]	4/1/22

Distribution: **WHITE/YELLOW** – Responder, **PINK** – Patient keeps

Distribution upon completion: **WHITE** – Health Record, **YELLOW** – Return to Patient with Response

Melisa Holdway
Psychology Associate

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